**BY ORDER OF**
**THE SECRETARY OF THE AIR FORCE**

**AIR FORCE TACTICS, TECHNIQUES AND PROCEDURES 3-42.9**

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***Tactical Doctrine***

# GLOBAL HEALTH ENGAGEMENT AND INTERNATIONAL HEALTH SPECIALIST TEAMS

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**PURPOSE:** The Air Force Tactics, Techniques, and Procedures (AFTTP) 3-42 series of publications is the primary reference for medical support capability. AFTTP 3-42.9 provides tactics, techniques, and procedures (TTP) for Air Force Medical Service (AFMS) Global Health Engagement (GHE), including the International Health Specialist (IHS) teams and the Defense Institute for Medical Operations (DIMO). These capabilities function across the range of military operations (ROMO) from peacetime security cooperation to combat operations and stability operations. This AFTTP provides strategic focus and tactical level guidance for GHE execution. It also outlines the way ahead for the AFMS to synchronize GHE capabilities to support the Air Force Global Partnership Strategy (AFGPS) and contribute to building partnerships (BP). This guidance is intended to help planners integrate the IHS Regional Health Specialist Team (unit type code [UTC] FFHSR) into military operations that may require interaction with US government agencies, including but not limited to other Department of Defense (DOD) services, Department of State (DOS), United States Agency for International Development (USAID), and United States Public Health Service (USPHS), or interactions with foreign or international military, government, or private agencies or organizations. Refer recommended changes and questions about this publication to the Office of Primary Responsibility (OPR) using AF Form 847, *Recommendation for Change of Publication.* Route AF 847 through the appropriate functional chain of command. Ensure that all records created as a result of the processes prescribed in this publication are maintained in accordance with (IAW) Air Force Manual (AFMAN) 33-363, *Management of Records*, and disposed of IAW the Air Force Records Information Management System (AFRIMS) Records Disposition Schedule (RDS). The use of the name or mark of any specific manufacturer, commercial product, commodity, or service in the publication does not imply endorsement by the Air Force.

**SUMMARY OF REVISIONS:** This revision combines AFTTP 3-42.9 and AFFTP 3-42.91 and changes the title. Chapter 1, Global Health Engagement, addresses the Air Force's role in

interfacing with international and host nation (HN) healthcare resources. Chapter 2, International Health Specialist Teams, describes the mission, structure, and deployment of UTC FFHSR. The content has been significantly updated and should be completely reviewed.

**APPLICATION:** This publication applies to all Air Force military and civilian personnel, including Air Force Reserve Command (AFRC) and Air National Guard (ANG) units and members supporting expeditionary ground medical (non-Special Operations Forces [SOF]) operations. The doctrine in this document is authoritative but not directive.

**SCOPE:** Chapter 1 of this document defines GHE and describes how AFMS personnel interface with global health organizations throughout the full spectrum of operations. It discusses the direction and processes required for successful assessment, planning, strategic communication, and execution of the international AFMS mission. Chapter 2 provides the TTP for the IHS team. This AFTTP may be used as a guide for developing standardized policies, operating procedures, and training concepts. Air Combat Command (ACC) is the Manpower and Equipment Force Packaging (MEFPAK) Responsible Agency (MRA) for expeditionary ground medical IHS packages. (**Note:** IHS SOF support is outside the scope of this AFTTP. Air Force Special Operations Command [AFSOC] is the MRA for AFSOC/SOF IHS packages and develops operational planning concepts to support SOF operations.)

# Chapter 1

# GLOBAL HEALTH ENGAGEMENT (GHE)

## *Section 1A—Introduction*

**1.1. Purpose.** The health resources available to support military deployments are finite. Interfacing with international and host nation (HN) resources can greatly expand the military's deployed health capabilities. However, to be effective, the Air Force Medical Service (AFMS) must know what international health resources are available and how to develop cooperation and collaboration.

**1.2. Global Health Definition.** Global health takes into consideration all aspects that affect the biological, psychological, and social wellness of individuals and international populations. It includes health systems, patient care, all health disciplines, economics of health, health governance, international policies and standards, and international law. Stakeholders include but are not limited to the following:

- Medical systems in the US such as the Centers for Disease Control and Prevention (CDC), United States Agency for International Development (USAID) (including the Office of United States Foreign Disaster Assistance [OFDA]), Department of State (DOS), United States Public Health Service (USPHS), and the other US military services

- HN elements such as the ministries of health and defense and private and public health networks

- Disaster relief (DR) networks (networks of governmental and non-governmental agencies and private entities that respond to local and international disasters), public health agencies, medical logistics, and transportation systems

- Intergovernmental organizations (IGOs) such as the World Health Organization (WHO), non-governmental organizations (NGOs), private voluntary organizations (PVOs), and international organizations (IOs) such as the International Federation of Red Cross and Red Crescent Societies (IFRC)

**1.3. GHE Definition**. GHE enables the Air Force to partner with other nations to build partner capacity and support security cooperation. Through health related activities and exchanges, GHE builds trust and confidence primarily between DOD medical services and partner nation (PN) armed forces and, less directly, with foreign civilian authorities or agencies. This rapport facilitates information exchange, coordination of activities of mutual benefit, and enhanced interoperability. GHE operates across the full spectrum of health capabilities in support of combatant commander (CCDR) end-state objectives (DODD 3000.07, *Irregular Warfare,* and AFI 44-162, *International Health Specialist (IHS) Program*).

**1.3.1. Monitoring and Evaluation (M&E)**. M&E is fundamental in the planning, execution, and assessment of AFMS GHE. Program planning must include appropriate

measures that link actions to short and long-term CCDR objectives as well as positive and preferably enduring health outcomes for civilian and security sector partners. See Attachment 3 for an M&E framework.

**1.3.2. Strategic Communication.** Strategic communication is defined as focused United States Government (USG) efforts to understand and engage key audiences to create, strengthen, or preserve conditions favorable for the advancement of USG interests, policies, and objectives through the use of coordinated programs, plans, themes, messages, and products synchronized with the actions of all instruments of national power. (JP 5-0). The AFMS GHE Strategic Communications Plan provides guidance and key messages under three main themes: (1) Prevent – focused on building partnerships; (2) Protect – focused on enhancing partner capabilities; and (3) Respond – emphasizing the AFMS desire for interoperable function with coalition partners. GHE should incorporate these broad themes as well as commander-specific strategic communication messages into the planning of every activity or mission.

**1.4. GHE and Expeditionary Operations.** Today's expeditionary force requires Airmen with international insight, foreign language proficiency, cultural understanding, and regional expertise – men and women with the right skill sets to shape conditions and rapidly respond to the full spectrum of global operations. Essential capacities include health systems and public health knowledge, diplomacy skills, ability to cultivate personal and inter-organizational relationships within other cultures, and planning and programming supporting activities.

**1.4.1. US Strategic End States.**

**1.4.1.1**. **Access and Influence**. Extend the operational reach of joint forces through health-related activities that open doors and foster the establishment of trusting relationships with the PN's personnel.

**1.4.1.2. Biosecurity**. Enhance PN capability for force health protection (FHP) and health services regarding the International Health Regulations (IHR), health surveillance, and pandemic preparedness and response. Biosecurity activities help protect the health of our own forces and contribute to national and DOD strategies for countering biological threats.

**1.4.1.3. Capability and Coalition Development**. Optimize PN airpower concepts (light, lean, and lifesaving) through exchanges and training on aeromedical evacuation (AE), expeditionary medical support (EMEDS), health services, humanitarian assistance, and disaster relief (HA/DR). The long-term goal of these activities is interoperable medical support between the PN and US forces and its allies and development of a coalition of partners.

**1.4.2. Health Security Cooperation.** These health operations include activities designed to prepare the strategic infrastructure during the pre-deployment phase and facilitate initial deployments in an area of responsibility (AOR). This objective is achieved primarily by

well-planned and well-synchronized GHE activities in support of the combatant command Theater Campaign Plan (TCP).

**1.4.3. Building Partnerships (BP).** BP emphasizes collaboration with foreign governments, militaries, populations, USG departments and agencies, public and private industry, IOs, and NGOs. BP is a joint capability area (JCA). It includes the sub-elements *Communicate* and *Shape*.

**1.4.3.1.** ***Communicate*** is the ability to develop and present information to current and desired allies, competitors, and adversary audiences to affect their perceptions, will, behavior, and capabilities to further US national security or shared global security interests. It also refers to developing and presenting information to domestic audiences to improve understanding.

**1.4.3.2.** ***Shape*** refers to conducting activities to affect the perceptions, will, behavior, and capabilities of partner, competitor, or adversary leaders, military forces, and relevant populations to further US national security or shared global security interests.

**1.4.4. Integrated and Interoperable Aerospace Medicine.** The AFMS needs to interface with global health systems and partners and include these concepts in every strategic plan for the operational theater. The TCP must consider the level of interaction with the nations in the region and the level of sophistication of their healthcare systems. When in doubt, consultation with regional experts, such as regional international health specialist (IHS) teams, can be beneficial.

**1.4.5. Medical Stability Operations (MSO).** Stability operations encompass military missions, tasks, and activities conducted outside the US in coordination with other instruments of national power to maintain or reestablish a safe and secure environment and provide essential governmental services, emergency infrastructure reconstruction, and humanitarian relief. MSO objectives could include the restoration of services such as water, sanitation, public health, and essential medical care. The desired end state is an indigenous capacity of the HN to provide vital health services to its people. In these types of operations, a civilian USG agency will typically serve as the lead. However, US military forces should be prepared to lead the activities necessary to accomplish these tasks when indigenous civil, USG, multinational, or international capacity does not exist or is incapable of assuming responsibility. Once legitimate civil authority is prepared to conduct these tasks, US military forces may support these activities as required or necessary.

**1.4.6. Humanitarian Assistance (HA)/Humanitarian and Civic Assistance (HCA).** HA and HCA activities are powerful and relatively inexpensive investments in building international relationships. Mission plans consider the HN's main concerns as prioritized by the US embassy country team and propose efficient solutions. A medical HA or HCA mission typically requires a 3-5 year follow-up plan that includes future missions to document the lessons learned of previous missions.

**1.4.7. Disaster Response and Preparedness.** The readiness training plan delineates a timely and effective response to the most likely catastrophic events in the CCDR's geographical region. The objective is to be ready to work with coalition partners in response to natural or man-made catastrophes, including terrorist acts and weapons of mass destruction (WMD) incidents. US medical forces exchange information with coalition partners and HN and regional disaster response organizations through academic institutions, training courses, and disaster response exercises.

**1.5. AFMS Assets.** Medical personnel support the Commander, Air Force Forces (COMAFFOR) in all AORs to accomplish specific regional goals in support of the global strategy. Personnel with global health skills help provide a smooth transition for deploying forces. In some instances, medical personnel may be the initial or only asset used to facilitate beneficial international relations and promote productive engagements with international partners and allies across multiple types of operations, including HA/DR, peacekeeping, homeland defense, and counterinsurgency (COIN). AFMS medical personnel specializing in an international arena possess skills and qualifications that uniquely support missions outside the continental United States (OCONUS). Seamless collaboration and interoperability in military-civilian partnerships optimizes the healthcare of US and allied military personnel.

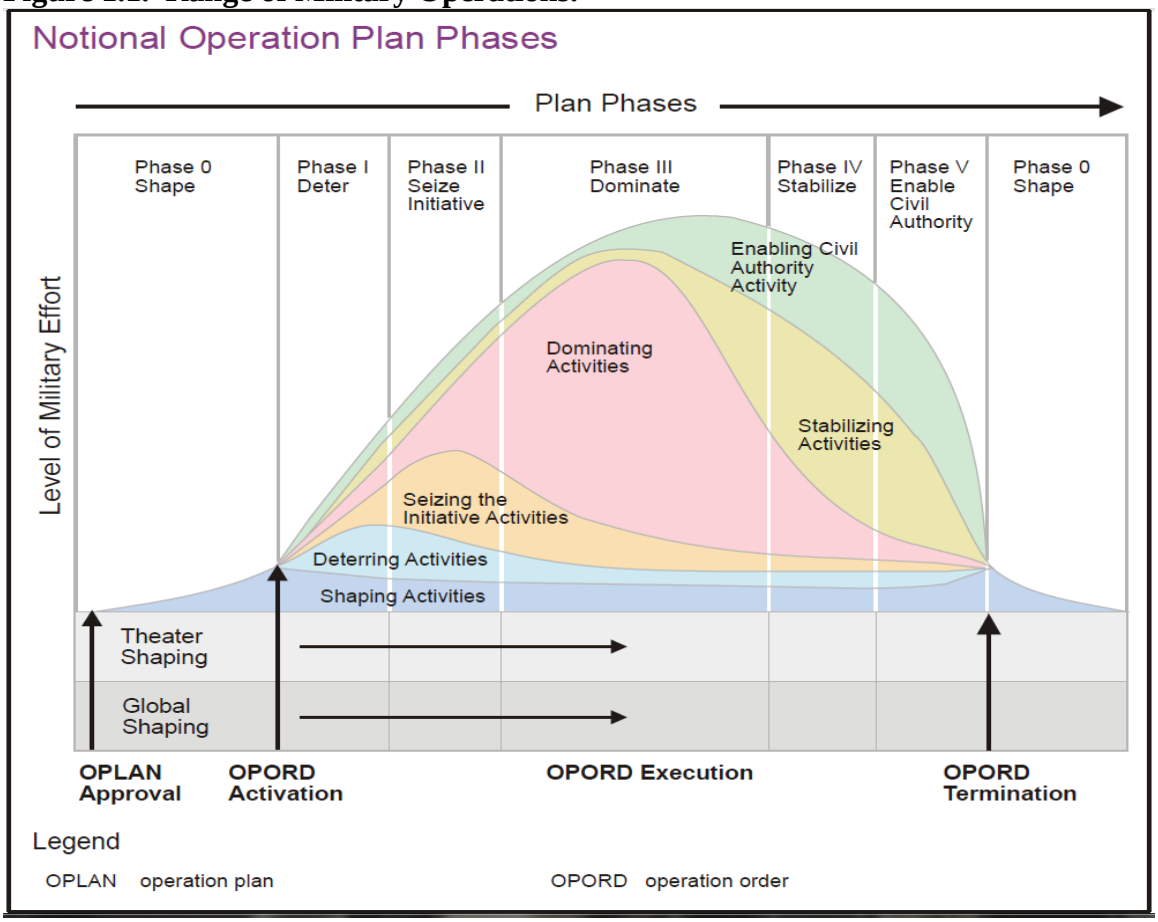
**1.5.1. Critical Personnel.** Regular Air Force (RegAF) and Air Force Reserve Component personnel who interface with global health leadership and systems include, but are not limited to, the deployed medical commander (DMC), Component Numbered Air Force Surgeon (C-NAF/SG), Major Command Surgeon (MAJCOM/SG), Joint Force Commander (JFC), Joint Force Air Component Commander (JFACC), COMAFFOR, Joint Force Surgeon (JFS), United States Military Group (USMILGP) personnel at US embassies worldwide, and medical planners. Full-time AFMS global health professionals contribute by maintaining knowledge of US global health national interests, a proactive and long-range view of health sector development, the ability to plan and execute GHE activities that support theater and combatant command objectives, cross-cultural and geopolitical competency, and foreign language proficiency. These personnel include IHS teams, Defense Institute for Medical Operations (DIMO) teams, members of the United States Air Force School of Aerospace Medicine (USAFSAM) International Training Division, and medical exchange officers.

**1.5.2. Special Operations Support.** IHS personnel may be assigned to Air Force Special Operations Command (AFSOC) and the United States Special Operations Command (USSOCOM) as combat aviation advisors (CAA), special mission officers, theater special operations, command medical operations officers, and Air Force Special Operations School instructors. Special operations IHS personnel are specially trained and organized to support the core tasks of USSOCOM in all theaters.

**1.6. Range of Operations.** GHE activities executed by AFMS personnel cover the full spectrum of military activities around the world. The AFMS supports the mission and objectives of the CCDR through direct support of the Air Component. These activities serve security cooperation, building partnership capacity (BPC) missions, and stability operations. They support the military and whole of government through the full range of military operations

(ROMO) (see Figure 1.1). Health sector objectives are intertwined with and support US military objectives and US national political interests in every type of operation.

**Figure 1.1. Range of Military Operations.**




**(Source JP 3-0, Joint Operations)**

**1.6.1. Limited Contingency Operations and Major Operations.** Combat support missions have a significantly greater risk component. All precautionary measures should be enacted when planning to engage with all facets of the HN medical system. For crisis response taskings, the pre-deployment window for initial forces may be short, but health engagement through all operational phases must be considered for the best long-term outcomes. Limited contingency operations may include ongoing irregular or stability operations that may involve long-term or recurrent actions without the forces or resources of a major campaign. GHE may find a larger future role in support of limited contingency operations that specifically involve COIN, military support to stability operations, and broader applications that fall within the concepts of irregular warfare as an essential service for disgruntled populations. Health activities that deliver personal care, generate local health sector capability and capacity building, and provide positive strategic messaging can be applied with altruism and still be a political and military tool to gain long-term influence and partnership.

**1.6.2. Humanitarian Assistance (HA).** HA operations are elective missions supporting requests typically made by ministers of health (or equivalent) to US embassies to aid civilian populations. HA missions can benefit medical personnel by exposing them to unique medical situations and conditions outside their normal duties. Requests for assistance are coordinated through the DOS for approval and to the CCDR for mission prioritization. The mission may be in a peaceful situation, primarily for security cooperation, or it may be in an area of conflict and part of a limited contingency operation in support of COIN or stability operations. The goals associated with the HA mission should generate long-term positive public relations and goodwill between the HN and DOD and help build security and sustainable stability within the host nation. Planners should prepare by fully understanding the purpose and scope of the mission and ensure the force is adequately supplied and manned.

**1.6.3. Disaster Relief (DR).** DR missions are contingency response HA missions, typically with a limited objective of delivering prompt aid to relieve human suffering. Normally, DR includes humanitarian services and transportation; provision of food, clothing, medicine, beds and bedding, temporary shelter and housing; furnishing of medical materiel and medical and technical personnel; and making repairs to essential services, as defined in JP 3-29, *Foreign Humanitarian Assistance*. The USG may be asked for aid and then task the DOD to support the USG effort. The disaster may be solely the result of an abrupt natural phenomenon or may be concurrent with conflict or combat (complex emergency), elevating the level of required risk preparation. Taskings typically have a very short pre-deployment window resulting in limited time to ensure mission readiness.

**1.6.4. Transition and Termination of Healthcare Support.** AFMS planners play a major role in the transition and termination of military healthcare support and assisting civilian organizations in clarifying US military activities in the health sector. Examples of indicators that assist commanders in timing a smooth termination of the mission in armed conflict include successful restoration of healthcare facilities and medical supply warehouses, an acceptable drop in mortality rates, a percentage of dislocated civilians returning to their homes, or a decrease in civilians reporting with blast injuries. When other organizations (such as HN, United Nations [UN], NGOs, and IOs) have marshaled the necessary medical capabilities to assume the mission, AFMS forces may execute a transition plan.

**1.6.5. Peace Operations.** The peacekeeper's main function is to establish a presence to inhibit hostile actions by the disputing parties and to bolster confidence in the peace process. The DMC must be aware of special technical agreements with other services and agencies regarding emergency care services and healthcare logistics. Medical and dental peacekeeping operations enhance positive response of the local populace to military personnel and hopefully the host partner government.

**1.7. Goals.** Two goals associated with GHE are enhancing cultural aptitude and providing mission support.

**1.7.1. Cultural Aptitude.** Enhancing cultural exchange through language proficiency, awareness and understanding of local customs, and experience working within international

settings helps ensure the AFMS' ability to meet assigned taskings, build partnerships, and support the full ROMO.

**1.7.2. Mission Support.** The AFMS supports the DOS, CCDR, and COMAFFOR's specific regional goals (as identified in strategic-level documents such as the Guidance for Employment of the Force [GEF]) through GHE and interaction with local, regional, and international healthcare organizations. Successful interface and coordination with these organizations requires accurate assessment of medical resources and capabilities. It requires knowledge of how these organizations operate and interact with each other and with the USG and DOD in particular.

***Section 1B—Roles and Responsibilities***

**1.8. Military Roles.**

**1.8.1. Deputy Undersecretary of the Air Force for International Affairs (SAF/IA).** The SAF/IA is the lead Headquarters, Air Force (HAF) agent for building global partnerships. The SAF/IA coordinates development of the Air Force global partnership strategy and oversees its execution in support of the combatant commands in coordination with other HAF organizations, MAJCOMs, and Air Force components (regular Air Force and Air Reserve Component [ARC]).

**1.8.2. United States Military Group (USMILGP) Embassy Team.** USMILGP facilitates relationships between deployed Air Force medical personnel and local health authorities and organizations. Deploying commanders should make contact with the USMILGP before arrival in country. USMILGP offices can advise AFMS personnel on whether the environment for medical operations is permissive, uncertain, or hostile. The USMILGP should also be able to provide background information on the HN health care system, its capabilities, deficits, structure, and locations at the national, regional, and local levels.

**1.8.3. Combatant Commander (CCDR).** The CCDR requests medical assets to support operations in the AOR in accordance with (IAW) the TCP or contingency operation plan (OPLAN). The CCDR communicates and coordinates with SAF/IA, USMILGP, and the C-NAF or Air Force Surgeon General (AF/SG).

**1.8.4. Major Commands (MAJCOMs) and Component Numbered Air Forces (C-NAFs).** MAJCOMs and C-NAFs organize, train, and equip Air Force units to support global partnership activities. They review on-going and new international activities on a regular basis to ensure activities continue to support combatant command objectives and Air Force strategy. Through the A5, they work with CCDRs to develop theater security cooperation and similar plans, ensuring that AFMS assess, train, advise, and assist capabilities are incorporated into these plans as needed. They receive requests for medical support from the combatant command surgeon or in-country team. The C-NAF validates all requests and sources team requests through the MAJCOMs.

**1.8.5. Commander, Air Force Forces (COMAFFOR).** The COMAFFOR has visibility of all medical assets available and understands the multinational context of healthcare in the AOR. In interaction with allied forces and HN leadership, the COMAFFOR is alerted to HN medical concerns that warrant the attention of the Air Force Forces Surgeon (AFFOR/SG).

## 1.9. AFMS Responsibilities.

**1.9.1. Air Force Surgeon General.** The AF/SG advises the Chief of Staff, United States Air Force (CSAF) on the Air Force medical assets available to support any contingency operation. The AF/SG provides information on US, allied, and HN medical capabilities. The AF/SG promotes interoperability of Air Force medical assets with joint, international, and HN healthcare through effective training and planning.

**1.9.2. IHS Consultant to the AF/SG**. As the adviser to the AF/SG, the IHS consultant offers insight into staff capabilities in terms of cultural expertise, language proficiency, special experience identifier (SEI), and medical expertise. The consultant offers recommendations on planning and execution of GHE and the training of expeditionary and global health assets at the enterprise level. The consultant acts in an advisory capacity for the geographic IHS teams' tactical execution and coordination. The consultant is the point of contact (POC) for military medical education personnel exchanges and oversees DIMO as well as the IHS program.

**1.9.3. Air Force Forces Surgeon (AFFOR/SG).** The AFFOR/SG directs Air Force health service operations and advises the COMAFFOR on all aspects of medical care that may affect mission accomplishment. The AFFOR/SG is supported by the DMCs, IHS team chief, DIMO, and senior medical personnel.

**1.9.4. Major Command Surgeon (MAJCOM/SG), Air National Guard Surgeon (ANG/SG), and Air Force Reserve Command Surgeon (AFRC/SG).** Command surgeons are charged with identifying units or personnel to support medical missions, including special operations missions. The allocation and training of medical personnel supporting special operations missions and use of HN healthcare may differ from the approach in traditional expeditionary or humanitarian operations.

**1.9.5. Air Force Expeditionary Medical Readiness Division (AF/SG3X).** AF/SG3X oversees the development of AF/SG policies supporting Air Force expeditionary capabilities and national security strategy. The International Health Specialist branch (AFMSA/SG3XI) located at the Air Force Medical Support Agency, Medical Readiness Directorate (AFMSA/SG3X), is responsible for organizing, training, and equipping IHS staff members for MAJCOM, combatant command, and DIMO assignments.

**1.9.6. Continental United States (CONUS) Medical Treatment Facility (MTF) Commander.** The MTF commander identifies personnel with the skills and qualifications required for unit type code (UTC) assignment or special taskings. The MTF commander directs personnel to appropriate training and ensures that personnel tasked for overseas operations are familiar with the healthcare environment in their deployed location.

**1.9.7. Public Health Officers (PHOs).** PHOs offer the COMAFFOR and AFFOR/SG regional medical surveillance skills that support the execution of war and other contingency operations. As a tasked advanced echelon (ADVON) team member, public health personnel may make the first interface with HN personnel and must be familiar with local issues affecting healthcare.

**1.9.8. Air Force Senior Medical Officer (SMO).** The SMO may be a DMC, task force surgeon, IHS team chief, or medical leader deployed in a different role. The SMO establishes the framework of cooperative efforts with HN medical personnel. This person must be familiar with the rules of engagement for the operation. The SMO advises the chain of command on all medical data gathered from the AOR. Every opportunity should be made to preserve and enhance established relationships with the HN before deployment of medical assets. IHS team members and IHS SEI holders should be used to the greatest extent possible.

**1.9.9. Deployed Medical Personnel.** All medical personnel engaged in international activities should be familiar with the HN medical capability, including caregiver levels of training and expertise, facility capacity, and resources. Medical personnel should be aware of unique cultural differences within the HN healthcare system, especially in those rare circumstances when US forces may receive care at HN facilities. In the absence of dedicated IHS personnel, deployed medical personnel should take advantage of other military language specialists to provide interpretation expertise necessary for safe and effective healthcare delivery.

## 1.10. Other Assets and Organizations.

**1.10.1. International Organizations (IOs), Governmental Agencies, and Non-Governmental Organizations (NGOs).** IOs, government agencies, and NGOs are excellent resources for medical data sharing. Relationships with these organizations should be based on mutual understanding of lines of communication, support requirements, and information sharing. To the extent possible, the AFMS should promote cooperation and information exchange with these agencies through a formal mechanism such as a Civil-Military Operations Center (CMOC). The philosophies and political views of these organizations vary widely and should be considered before establishing an alliance. Interactions between some NGOs and the AFMS may be impossible to negotiate because such cooperation may run counter to their charter or founding principles.

**1.10.2. National Center for Medical Intelligence (NCMI) and Defense Intelligence Agency (DIA).** These agencies offer comprehensive information on international healthcare capabilities, regional environment, and threat levels. Their research may be used by senior medical officers in preparation for medical operations.

**1.10.3. Air Force Security Assistance Training (AFSAT) Squadron.** AFSAT's mission is to plan, develop, program, and execute training and education programs that enhance strategic relationships and agreements and help strengthen worldwide alliances in support of

US national security strategy. The agency serves as the executive agent for all Air Force sponsored international training.

***Section 1C—Planning for Global Health Engagement***

**1.11. Integrated Planning.** Integrated health sector planning enhances the protection of Air Force expeditionary forces while furthering the objectives of commanders. All deliberate, crisis-action exercise and theater security cooperation planning processes should include international healthcare experts with operational experience at the strategic and operational levels. IHS personnel on the MAJCOM, C-NAF, and CCDR Surgeon General staffs should participate in planning although they do not make decisions about OPLANs and exercises. They should assist with developing guidance on theater objectives. They should review proposed medical projects and after action reports (AARs) to ensure objectives are identified and aligned with theater objectives. IHS personnel should provide information on PN POCs in the AOR, such as ministry of health (MOH), ministry of defense (MOD), and military groups. Medical planners require detailed information on healthcare systems in identified locations to support OPLANs and concepts of operations (CONOPS). This information should include details on the national healthcare infrastructures, availability of medical specialties, and access to evacuation assets, potential health hazards, environmental threats, and cultural and political sensitivities that may impact the health of deployed forces. In planning and executing GHE activities, IHS personnel should stress the need to adhere to North Atlantic Treaty Organization (NATO) and USAID's reconstruction principles.

**1.12. Reconstruction Principles**. USAID's key principles for successful reconstruction and development efforts are critical concepts for GHE capacity-building initiatives.

- Ownership: Build on leadership, participation, and commitment of a country and its people.
- Capacity Building: Strengthen local institutions, transfer technical skills, and promote appropriate policies. (**Note:** Help build or enhance capability and then partner to increase capability breadth and impact.)
- Sustainability: Design programs to ensure their impact endures.
- Selectivity: Allocate resources based on need, local commitment, and foreign policy interests.
- Assessment: Conduct careful research, adapt best practices, and design for local conditions.
- Results: Direct resources to achieve clearly defined, measurable, and strategically focused objectives.
- Partnership: Collaborate closely with governments, commitments, donors, non-profit organizations, private sector, IOs, and universities.

- Flexibility: Adjust to changing conditions, take advantage of opportunities, and maximize efficiency.

- Accountability: Design accountability and transparency into systems and build effective checks and balances to guard against corruption.

**1.13. Exercise Planning.** The AFMS provides medical support planning for specific training exercises to support OPLANs and CONOPS occurring in foreign nations. Exercises such as COBRA GOLD, BRIGHT STAR, and ULCHI FREEDOM GUARDIAN are examples of planned exercises. The planning for these exercises occurs at the CCDR and MAJCOM levels over a period of several months before the exercise. MAJCOMs should include IHS personnel with language and operational experience for the exercise locations in their exercise planning and deployments. PN participation in exercises helps identify capability gaps that IHS staff can work to improve.

**1.14. Theater Campaign Planning.** Air Force GHE activities are normally conducted in support of COMAFFOR campaign support plans and country plans, which support the CCDR TCP. The CCDR TCP identifies the objectives, mission focus, and direction for interaction with each country in the theater. The TCP is based on a 5-7 year planning timeframe and is mainly created for peacetime, permissive environments. The AFMS IHS program provides expertise to CCDRs for the planning and execution of medical interactions for the TCP and COMAFFOR supporting plans. As an example, the United States Central Command (USCENTCOM) Surgeon's Office has an IHS team on staff whose members are responsible for developing specific regional medical plans within the USCENTCOM AOR.

**1.15. Planning Considerations.** While focusing on PN military resources, GHE plans must identify and consider the whole health sector, which includes private, public, and military health systems, direct patient care, public health, and the critical governance and economic aspects that affect health. Planners should consider the HN's foundational health sector needs, which typically include public health issues such as sanitation, potable water, nutrition, immunization, disease surveillance and prevention, maternal and child health, veterinary medicine, dental, environmental health, industrial health, and HN AE. Planners should design the correct type of activity to attain objectives. For instance, direct patient care may not always be the right choice and could undermine relationship building, local health sector economics and development, and long-term positive outcomes. GHE planning and execution requires international health information derived from and coordination with various organizations, such as the NCMI, CDC, US Global Health Initiative, and international sources such as the WHO.

**1.15.1. Medical Intelligence Preparation.** Medical intelligence preparation considers the potential health threats that the partner health sector faces as well as the threats to US forces.

**1.15.1.1. Theater Assessment.** Theater assessment considers the joint, coalition, and PN military and civilian capabilities and capacities. It also considers socio-political and cultural aspects and regional nuances.

**1.15.1.2. Health Risk Assessment.** Health risk assessments anticipate, identify, and assess health threats to military personnel, partners, and target patient care population. It includes environmental, man-made, and industrial hazards.

**1.15.1.3. Medical Threat Assessment**. Medical threat assessments consider specific diseases that may affect military personnel as well as diseases and occupational issues with great local impact that may be of low threat for US forces. For example our US forces may be vaccinated against measles or pertussis, but the local population may have low vaccination rates.

**1.15.1.4. Needs Assessment.** Needs assessment considers the PN's military and civilian health sector gaps and priorities to determine if the US has capabilities that can assist. The AFMS focuses on military health sector gaps. The DOS and USAID focus on the civilian sector.

**1.15.1.5. Outcomes Assessment.** Outcomes assessment is done as a baseline and then at various intervals during and after the engagement. The goal is to have objective measurements that demonstrate attainment of objectives (also called measures of performance [MOPs] and measures of effectiveness [MOE]).

**1.15.2. Force Health Protection Considerations.** In GHE missions, US forces may be acting as first responders with partners and may not have readily available access to the higher level capabilities expected in US systems. Austere environments may offer patient movement challenges that require planning consideration. Personnel responding to human tragedy or working with long-term human suffering may experience significant physical and emotional effects that should also be considered.

**1.15.3. Medical Rules of Engagement.** Clearly defined medical rules of engagement help US medical personnel in all types of operations. AFMS leadership and planners should determine in advance the plan for the provision of care to HN personnel and other civilians. The plan should include who gets direct patient care, which facilities will provide care, standard of care, disposition of patients to the HN or international community care, availability of AE, and cooperation on displaced personnel health issues.

**1.15.4. Resources and Interoperability.** The packaging of personnel and equipment for health engagement operations is tailored to the mission. For example, DR operations may require a primarily surgical presence initially while a security cooperation campaign may focus on public health advisors. The AFMS must be integrated with the line responders, and medical plans should be coordinated with other functional areas to ensure synergy. Interoperability with sister services and the HN is also paramount.

**1.15.5. Transition Planning.** Ultimately, the HN or designee will need to run their own health sector programs and efforts at the level of standards that their resources allow and their culture accepts. To maximize the positive outcomes for US efforts, planners must coordinate early, determine who the lead is and who will take over, emphasize support and advising when possible, and help define and then focus on the commander's objectives from

the beginning. In most cases, planning to enhance HN legitimacy in the health sector will be a win-win.

**1.15.6. Examples of Health Engagement Activities.** The AFMS has the ability to support a wide variety of health engagement activities that can be tailored to the needs of the HN or partner. To achieve enduring, strategic results, planners should prioritize activities that build PN capacity over direct intervention. Medical Readiness Training Exercises (MEDRETEs) and Medical Civic Action Programs (MEDCAPs) may include one or any combination of activities as dictated by the objectives, needs, planning considerations, and funding. The following are some examples of health engagement activities:

- EMEDS
- HN public health, preventive medicine, veterinary, dental augmentation
- Health system mentoring and advising
- Paramedic capability development
- FHP
- Emergent and disaster response capability development
- Disaster response exercise planning and execution
- Combat exercises
- Combat casualty care training
- Military and civilian medical logistics programs
- Health worker education programs
- Skill-specific mentorship
- Military and civilian medical intelligence
- Hospital and clinical system management
- Sustainable infrastructure and upgrade of existing facilities
- Public information programs
- Health sector assessments
- Direct patient care
- Conferences, seminars, workshops
- HA program
- Disease surveillance
- National Guard state partnership program
- University partnership (academic exchanges)
- Medical embedded training teams
- Provincial reconstruction teams
- HN patient movement capabilities
- Health indicators assessment

## *Section 1D—Operational Considerations for Deployed Medical Commanders*

### 1.16. Pre-Deployment Activities.

**1.16.1. Mission Communication.** The DMC/SMO should understand and communicate the mission scope and purpose to HN officials and deploying team members ahead of time. It is important for the DMC/SMO to understand US politics and policy and know whether coordination should be turned over to Public Affairs. IHS staff support strategic communication endeavors by providing cultural and foreign language expertise.

**1.16.2. NGO Participation.** The mission of NGOs and other global health actors frequently diverge from those of the DOD. When possible, DOD GHE personnel should seek to

actively collaborate in areas of shared interest. The next best option is cooperation whereby separate efforts support rather than hinder common goals. GHE planners must understand that NGOs are often better postured and resourced to sustain long-term activities with foreign partners. The United States Institute of Peace *Guidelines for Relations between US Armed Forces and Non-Governmental Humanitarian Organizations in Hostile or Potentially Hostile Environments* provide guidelines for interactions between US military and US NGOs in non-permissive environments. These guidelines were developed in concert with the DOD and InterAction (an umbrella organization for US NGOs)

**1.16.3. Security Requirements.** The DMC/SMO should know of any security requirements and restrictions. For example, ANG security forces were not allowed to carry weapons while providing security to a deployed clinic during PROVIDE COMFORT (an HA mission).

**1.16.4. Gift Donations.** The donation of culturally appropriate gifts to the HN and partner leadership can be a valuable relationship building tool. Gifts such as school supplies (e.g., pencils, pens, paper), clothing, and personal hygiene products (e.g., soap, shampoo) may be appropriate depending on the mission. DMCs should be cautious not to allow these gifts to affect mission success. Gift donations are often best done in conjunction with a local NGO. The local base legal office should be consulted for any gift donation. The Defense Institute for Security Assistance Management (DISAM) can provide additional guidance on gift donation.

**1.16.5. Site Survey Update.** Site surveys involve communicating with HN medical personnel to obtain updated information about medical capabilities and facilities at anticipated locations. A plan to meet requirements from the HN infrastructure should be processed through the military liaison or CCDR surgeon.

**1.16.6. Liaison Coordination.** If a task force surgeon is not in place, the DMC/SMO may need to coordinate directly with the US embassy through the military group or the embassy health program representative. Typically, a USAID representative manages HN or regional health programs if there is not an official health attaché from the Department of Health and Human Services (DHHS). The combatant command surgeon should also be used as a reachback capability. Other resources include US expatriates, US private companies, and HN personnel operating in the US as liaison officers (LNOs).

**1.16.7. Historical Document Review.** Before deployment, DMCs should review previous operations and exercises in the Theater Security Cooperation Management Information System (TSCMIS), AARs, and lessons learned. AARs and lessons learned should be accessible from the supported combatant command surgeon or supported MAJCOM.

**1.16.8. Host Nation Health Information and Medical Intelligence.** The DMC should ensure the currency of medical intelligence and HN medical information (e.g., hospital contact and capabilities information) before and throughout the deployment. The DMC should review local health threats, disease and injury reports, and disease surveillance.

## 1.17. Deployment Activities.

**1.17.1. Establish Direct Communications.** Once authorized direct liaison authority by the US embassy, the DMC/SMO should make communication channels between HN medical facilities and US medical interests a priority. Robust and open communications facilitate optimal care for deployed US troops. All formal and informal communication channels should be used.

**1.17.1.1. Direct Contact with HN Medical System.** Staff members of the deployed medical facility who directly interact with the HN medical system provide key information about medical care and the environment in the AOR. This information should be reported up the chain of command.

**1.17.1.2. Assessment of Host Nation Infrastructure.** The DMC and Air Force LNO along with Judge Advocate General (JAG) officials should ensure standards of care and quality of supplies and services meet AFMS standards for care of US personnel. It may be necessary to consider increasing the medical footprint of the deployed medical system or to establish rapid, reliable AE capabilities. Memorandums of understanding (MOUs), memorandums of agreement (MOAs), and contracts should be the primary communication for all formal relations with the HN medical infrastructure.

**1.17.1.3. Participation in HN and Joint Medical Planning Activities.** Deployed commanders are strongly encouraged to participate in HN and joint planning for new contingencies while in the AOR. Medical data gathered at these meetings can facilitate medical treatment and augment local capabilities.

**1.17.2. Maintain Air Force Liaison Officer Relations.** To the extent possible, a medical LNO should be assigned to ensure daily contact with HN infrastructure to support quality assurance in all formal relations with the HN and continued informal partnerships.

**1.17.3. Information Sharing.** The DMC/SMO should share appropriate information with the HN medical system such as disease and injury rates, mass casualty patient administration and collateral damage assessments, and medical infrastructure capabilities.

**1.17.4. Informal Relationships with Host Nation.** Informal relationships with local populations often provide more current and relevant information about the local area than the information obtained through official sources. In some cultures, these relationships may take generations to establish. Cordial communications and building genuine, trusting relationships should be a goal. The process of establishing informal lines of communication should be initiated immediately upon arrival in theater. The DMC and medical personnel should expect to meet with local officials immediately upon arrival at a deployed site and should plan for extensive and regular discussion and coordination to solidify mutual understanding.

**1.17.5. Transition Briefs.** The DMC/SMO provides transition briefs for new US personnel coming into the AOR. Briefs should include standard facets, personal introductions to key

players and counterparts, and a summary of host medical facility capabilities. Local cultural practices and policies should be shared at all levels. The staff IHS officer or noncommissioned officer (NCO) can assist with these briefs.

**1.18. Redeployment Activities.**

**1.18.1. Update Medical Information.** HN medical capabilities and other information should be recorded and communicated. Commanders should share lessons learned and best practices through AARs and lessons learned databases IAW AFI 10-204, *Participation in Joint and National Exercises,* and AFI 90-1601, *Air Force Lessons Learned Program*. AARs and daily summaries should focus on the skills that were transferred between medical professionals, capture measures of effectiveness, and provide context for follow-on personnel. MOEs must be reviewed at appropriate intervals to determine if the desired impact was achieved and to inform plans to continue, improve, or terminate future similar missions.

**1.18.2. Post-Operational Medical Liaison.** Relationships with the HN may continue to be nurtured and expanded after redeployment within the guidelines established by the combatant command or air component surgeon.

***Section 1E—Dedicated AFMS and DOD Programs***

**1.19. International Health Specialist Program.** The IHS Program Office develops and maintains information on individual IHS personnel to include foreign language proficiency, SEI level, formal education, and international health and deployment experience. Their focus is on skills specific to interagency coordination, security cooperation, and cultural, political, sociological, economic, and geographic factors affecting the health sector of countries and regions in which US Forces may operate. IHS personnel are AFMS personnel with identified cultural expertise, language proficiency, and medical skills. The individual IHS SEI holder is responsible for maintaining language proficiency and IHS core competencies. See AFI 44-162 for more information about the IHS program. See Chapter 2 of this AFTTP for more information about the IHS team.

**1.20. Defense Institute for Medical Operations (DIMO).** DIMO provides exportable, regionally focused healthcare education and training. DIMO's programs strive to improve security cooperation between militaries, improve civilian agency interaction, and strengthen international coalition partnerships. The Defense Security Cooperation Agency (DSCA), as the DOD focal point for international education and training, provides sponsorship through International Military Education and Training (IMET), foreign military sales (FMS), and other funding sources such as the Foreign Military Financing Program (FMFP).

**1.21. National Guard State Partnership Program (SPP).** The National Guard SPP is a joint security cooperation program managed by the National Guard Bureau (NGB) and executed by the state adjutant generals in support of CCDR security cooperation objectives and ambassador integrated country strategies under the authorities provided by DOD and Congress. The SPP matches a National Guard state with a PN to exchange military skills and experience, share

defense knowledge, enhance partner capability, and conduct GHE to support security cooperation goals. The SPP promotes enduring and mutually beneficial security relationships. It currently links 68 countries to all 50 states, 2 territories (Puerto Rico and Guam), and Washington D.C. See DODI 5111.20, *State Partnership Program (SPP),* for more information.

**1.22. Military Personnel Exchange Program (MPEP).** The MPEP, under legislative authority from the National Defense Authorization Act for fiscal year 1997, is owned by CSAF and executed by the Air Force Attaché Office. This program is executed through an MOA between the Air Force and each host country. Working towards achieving interoperability with a country, AFMS personnel provide assistance in establishing requirements for the MPEP and in developing a longitudinal plan for future exchanges.

***Section 1F—Education and Training***

**1.23. Global Health Engagement Awareness.** All Air Force medical personnel should have basic cultural awareness and understand their role in GHE. Resources for this training include the Air Force Advanced Distributed Learning Service (ADLS) cultural awareness module and the Air Force Cultural and Language Center. Line commanders, SGs, and other medical leaders and planners require an understanding of AFMS health engagement capabilities and how they can and should be employed throughout the ROMO. A subset of medical personnel should have comprehensive knowledge and aptitude for languages and cultures, global health systems, how to develop and leverage relationships, and how to use health engagements to maximize positive impacts and mitigate potential adverse impacts. This advanced training may come from formal academic programs and informal offerings from the global health and military communities.

**1.23.1. Special Operations Unit Training Capabilities.** As directed or required by the mission, special operations units may provide medical training in the HN IAW national security strategy.

**1.23.2. International Medical Conferences and Seminars.** Air Force personnel participate in and can contribute to medical conferences and seminars designed to further international military medical education, cooperation, and interoperability.

**1.23.3. Building Partnerships and Security Cooperation.** Air Force expeditionary medical personnel promote mutual understanding and increased cooperation between the US and the HN by participating in field training exercises in conjunction with partners. AFMS personnel with global health backgrounds and experience help plan exercises that maximize development for US and partner forces.

**1.23.4. DIMO Courses.** DIMO offers mobile training courses to host countries at the request of partners through the US embassy country team. Course offerings include public health and biosecurity, disaster planning and consequence management, healthcare management, and patient movement. Courses are funded by IMET, Expanded-International Military Education and Training (E-IMET), Combating Terrorism Fellowship Program (CTFP), FMS, FMFP, and HA sources.

**1.23.5. USAF Steady-State Campaign Support Planning Course.** This ADLS course provides training for C-NAF and AFFOR personnel to design, plan, prepare, execute, and assess steady-state campaigns in support of the COMAFFOR and CCDRs.

**1.24. International Education and Training.** The International Education and Training Program offers education and training to foreign governments and international organizations at DOD schools. International training includes formal, informal, correspondence, or other forms of distance learning, and computer-aided instruction. DOD medical agencies offering formal education and training opportunities for PNs include DIMO (see paragraph 1.20) and USAFSAM.

**1.24.1. Training Requests and Funding.** PN requests for international training are routed through the US embassy's security cooperation officer (SCO). PNs may purchase training with their national funds through the FMS program or through security cooperation appropriations such as the IMET program. These funds are congressional appropriated funds authorized annually by the DOS. Requests for training are typically programmed during each geographic combatant commander's (GCC) Security Cooperation Education and Training Working Group (SCETWG) and programmed with the military departments (MILDEPs) to identify training requirements. Upon receipt of funding authority, the MILDEPs authorize the SCO to prepare invitation travel orders (ITO) once the candidate's vetting is completed. Individual schools can be represented at each SCETWG if authorized by the applicable GCC staff. See Defense Security Cooperation Agency (DSCA) Manual 5105.38-M, *Security Assistance Management Manual* (Chapter 10, International Training), for more information about the policies, programs, and procedures related to the International Education and Training Program. AFI 16-105, *Joint Security Cooperation Education and Training*, provides additional information on the management of international education and training.

**1.24.2. United States Air Force School of Aerospace Medicine International Training Division (USAFSAM/ETO).** USAFSAM is the premier institute for research, education, and worldwide operational consultation in aerospace medicine. USAFSAM trains approximately 4,500 DOD, international, and civilian students each year. The USAFSAM International Training Division (USAFSAM/ETO) collaborates with the Registrar Division (USAFSAM/EDM) to manage all international training within USAFSAM. These courses promote English as the language of choice for medical operations and the globalization of many US practices. The six-month Advanced Aerospace Medicine for International Medical Officers (AAMIMO) course has been instrumental in establishing and maintaining partnerships with over 130 nations and is recognized as one of the premier courses for PN flight surgeons.

***Section 1G—Information Management***

**1.25. Information Management and Information Sharing Activities.** Interfacing with world healthcare involves sharing the expertise of the AFMS with world partners to build capacity, interoperability, and goodwill between the US and foreign medical infrastructures. Information

learned from past HN integration activities is available on the AFMS knowledge server website. Target audiences include AFMS senior leaders and EMEDS commanders.

**1.25.1. After Action and Trip Reports.** AARs provide documentation of previous missions and can be helpful for subsequent planning. IHS personnel should complete these reports IAW AFI 10-204 and AFI 90-1601 and forward a copy to the IHS Program Office. These reports will be entered into appropriate planning databases, such as TSCMIS. AARs should state the mission objectives and the extent to which they were achieved. They should include the names of AFMS personnel involved, the names of foreign medical personnel contacted, and the foreign medical facilities visited.

**1.25.2. National Center for Medical Intelligence (NCMI).** NCMI is the DOD agency that compiles information on foreign medical infrastructure, foreign military medical capability, and force protection information. Upon request, NCMI will produce specific products for the mission and location needed by DMCs, medical planners, or IHS subject matter experts (SMEs).

**1.25.3. Force Health Protection Information in Foreign Settings.** While NCMI and public health officers are the offices of primary responsibility for monitoring foreign disease issues that might affect deployed US military personnel, interfacing with local public health experts adds an understanding of the AOR's disease profiles from the HN's perspective.

**1.25.4. Latent Information Sharing Activities.** Theater-focused IHS teams are encouraged to synthesize and document in a standard format the capability of each geographically distinct region in their AOR to support deployed AFMS operations. Teams should actively monitor multiple sources to capture current knowledge of healthcare infrastructure, military medical capability, and FHP concerns of each country in the AOR.

**1.25.5. Sharing Expertise with Global Health Partners.** DIMO, working with combatant command staffs in support of the component commander's TCP, exports courses to foreign medical entities. These educational events create opportunities for Air Force personnel to interface with world healthcare. IHS team members are used on DIMO missions when instructor criteria are met. Regional teams should be aware of the range of DIMO offerings so they can support the DIMO office in marketing these capabilities to their associated combatant commands.

**1.26. Metrics.** Air Force offices with primary responsibilities for interfacing with world health officials use metrics to help quantify how Air Force personnel are supporting the CCDR's medical surveillance, planning, coordination, and operational activities. Metrics are used to justify resource allocations during the program objective memorandum (POM) process. Useful measures include the number of countries involved in joint and bilateral military exercises; the percentage of TCP-prioritized PNs with active medical lines of engagement; the number of countries with medical capabilities evaluated; the types and quantities of clinical services performed in foreign countries; DIMO course results and whether the HN develops a similar course; the number of international personnel attending IHS-sponsored training; and whether IHS team members have attained full SEI qualification. Mission-specific metrics should be

developed during the planning process and focus on commander objectives, local health needs, and accepted international health parameters.

# Chapter 2

# INTERNATIONAL HEALTH SPECIALIST (IHS) TEAMS

## *Section 2A—Capability*

**2.1. Background.** The Air Force initiated the IHS program to focus AFMS members educated in the language, culture, and politics of specific regions on building medical partnerships with other countries and agencies. IHS teams and individuals support CCDR TCPs, create partnerships with medical colleagues from nations within their regions, facilitate culturally appropriate military-to-military and military-to-civilian interactions, and support medical planning. IHS teams cross traditional medical career field lines to facilitate interoperability between the AFMS and other health and humanitarian organizations. Information about the program and reference materials are available on the IHS website: https://kx2.afms.mil/kj/kx4/InternationalHealthSpecialist/Pages/home.aspx.

**2.2. Mission.** The IHS is a cadre of AFMS personnel with foreign language proficiency, cross-cultural aptitude, and expertise in global public health and medical systems; joint, combined, and multi-agency operations; planning; strategic communication; and health diplomacy. IHS members are instrumental in fostering partnerships with military, civilian, coalition, and interagency personnel. IHS personnel can advise senior medical officers, SGs, AFFOR, and joint leadership on the effective use of medical assets across the ROMO and operational phases, particularly in the areas of GHE and direct support of TCP objectives. IHS personnel may deploy as individual augmentees or as part of small, deployable force packages that provide support tailored to the requirements identified by the country teams, combatant command surgeon, AFFOR, joint task force (JTF), or joint enabling tasking.

**2.3. Air Reserve Component (ARC) IHS Teams.** The AFRC and ANG do not have Reserve Component IHS UTCs. The RegAF ARC liaison is responsible for coordinating the use of individual SEI holders. Tasking may include self-initiated activities in support of geographic combatant command IHS requirements or the State Partnership Program, activities designed to augment another lead unit (e.g., Joint Chiefs of Staff [JCS] exercises), or direct Air and Space Expeditionary Force (AEF) tasking. RegAF IHS liaisons work within the force structure of the ARC to find qualified personnel to support international engagement missions based on requests from other DOD and government agencies. The individuals or units participate contingent on support from their wing or numbered air forces. Through combatant command contacts, ARC IHS commitments are often made years in advance for programmed activities. Response to short-notice taskings is possible but requires attention to fiscal and regulatory guidance that is often complicated. ARC IHS participation is performed in a variety of pay status from annual tour to manpower or reserve personnel appropriation (MPA/RPA) man days. C-NAF IHS teams should program MPA man days through their A1 Reserves Affairs to facilitate ARC augmentation for TCP events.

**2.4. FFHSR, Regional Health Specialist.** FFHSR provides personnel to deliver regional health specialist expertise to military and non-military operations such as major theater war (MTW), HA/DR, security cooperation, HN partnership building, stability and reconstruction operations,

and health sector capacity building. FFHSR may deploy with EMEDS Health Response Team (HRT) or as augmentation for AFFOR, JTF, and Commander, Joint Task Force (CJTF) headquarters. The regional health specialist provides area-specific insight and in-depth familiarity with HN, US and foreign government, non-governmental and international governmental health capabilities, and activities in the AOR. This individual helps guide execution of health engagement activities to support mission objectives and helps deployed commanders evaluate the medical dimensions of the operational environment in a cultural context and their implications to the mission and US FHP. Table 2-1 lists the manpower detail.

**Table 2-1. FFHSR Manpower Detail.**

| Title | AFSC | SEI | Grade | Quantity |
|---|---|---|---|---|
| Health Services Administrator | 041A3 | H8B | 04 | 1 |
| **Note:** Air Force Specialty Code (AFSC), grade, and skill-level substitutions are IAW the *War and Mobilization Plan, Volume 1 (WMP-1), AFMS Supplement,* AFI 10-403, *Deployment Planning and Execution,* and the mission capability (MISCAP) statement. | | | | |

**2.5. Primary Sourcing.** The C-NAFs or Component Major Commands (C-MAJCOMs) with full-time IHS personnel assigned provide RegAF medical personnel to support theater FFHSR requirements. Fully qualified AFMS personnel assigned at MTFs or other locations may fill FFHSR requirements postured within their MAJCOMs if no full-time regional IHS personnel are available for deployment.

**2.6. Additional Sourcing.** AFFOR may use volunteer forces from RegAF and ARC personnel (AFRC and ANG) to source specific FFHSR operational taskings. The IHS personnel database identifies AFMS volunteers with IHS core competencies who can be used to support specific combatant command operations and security cooperation initiatives. This database is centrally managed by the IHS Program Office with additional information provided by the Air Force Personnel Center (AFPC). IHS members in the SEI database remain under the control of their respective commands but can be identified to fill CCDR and AFFOR IHS requirements. At execution, command relationships are defined in the warning, execution, or deployment order.

**2.7. Selection for FFHSR.** Full-time IHS candidates who are nominated to fill an FFHSR mobility tasking will undergo a position-specific local validation process. The IHS Program Office provides IHS data support. RegAF or ARC candidates for FFHSR mobility positions must be worldwide qualified, meet IHS core competency requirements IAW AFI 44-162, and have a minimum of a Secret security clearance. ARC members will not fill RegAF IHS mobility billets but may volunteer for unfilled current operations and crisis response FFHSR taskings by nomination from the RegAF ARC IHS liaison.

**2.8. Assignment of IHS Personnel as Augmentees.** Personnel assigned to FFHSR are subject to deploy in support of military operations that take priority over local augmentation requirements. Members assigned to FFHSR as primaries and alternates should not be assigned augmentation duties until all other eligible resources are exhausted.

**2.9. Tasks.** IHS capabilities are tailored to the mission and operational context (e.g., specifically requested individual competencies or complete, exportable IHS generalist package).

The following are common tasks FFHSR performs in support of AFFOR, JTF, CJTF, or appropriate command. Mission-specific tasks should be defined in the tasking order.

**2.9.1. Diplomacy and Negotiation.** Multilateral health sector negotiations may involve a number of actors, including nations and other military and non-military stakeholders. They cover many issues often under conditions with uncertain levels of trust. Within their distinctive areas of expertise and applicable to US military objectives, FFHSR helps force commanders and medical advisors work through the key phases of multilateral negotiations (e.g., issue definition, fact-finding, bargaining, and agreement implementation, review, and strengthening) within a multi-cultural context.

**2.9.2. Cross-Cultural Insight of the Area of Operations (AO).** FFHSR is a force enhancer that helps commanders assess the operational environment, health threat, and health activities within a cultural context.

**2.9.3. Strategic Communication.** IHS members help force commanders, planners, and deployed medical personnel become aware of the cultural scripts involved in expeditionary, security cooperation, and health engagement activities to help ensure their transcultural instructional interactions will produce the desired results.

**2.9.4. Foreign Language Proficiency Appropriate to the Area of Operations (AO).** IHS members incorporate language skill and regional expertise into operational or contingency medical planning and execution. FFHSR provides foreign language proficiency directly or as an interface with interpreters hired to support AFMS and joint capabilities.

**2.9.5. Cooperation with US and Foreign Government Agencies, National Health Systems, NGOs, IOs, and PVOs.** US and foreign government agencies and organizations, HN, IO, NGO, and PVO health planning and health delivery activities provide services and expertise that enhance or may be enhanced by US military capabilities. Health sector stakeholders may have post-conflict or post-disaster capability, including presence on the ground as first-responders. They have the flexibility to deliver services in a fast-changing environment and long-standing presence and understanding of the local environment, culture, and health systems. The IHS team helps leverage relationships between the US military and these entities to deliver health activities that meet mission objectives and focus on unified action.

**2.9.5.1. Leveraging AO Resources.** IHS UTCs engage with regional IHS personnel at C-NAFs and rescue coordination centers (RCCs) as well as interagency contacts to help develop a health sector common operating picture for each mission. They use their expertise and contacts to engage with HN and regional military and civilian health experts as indicated to determine needs and appropriate activities.

**2.9.5.2. Facilitating Inter-Agency Coordination.** Within their respective scope and operational sphere, IHS teams interface with other US and foreign government agencies, HN health workers, IOs, NGOs, and PVOs on behalf of the task force commander and medical leadership. IHS teams can speak the language of civilian international health and

humanitarian stakeholders and potentially enhance existing relationships or create new ones.

**2.9.6. Foreign Humanitarian Assistance (FHA) and Disaster Relief (DR).** IHS may be tasked to augment medical planners and assessment teams in FHA/DR planning and execution. The standard FFHSR UTC provides AO-specific forward and tactical skills, knowledge, and awareness to assist deployed commanders and expeditionary platforms (such as EMEDS) in dealing with a wide range of medical and humanitarian crises from acute issues to enduring complex emergencies. When filled by a skilled O-5, FFHSR can support strategic and operational level headquarters assignments that require multi-agency, multi-cultural interactions with the HN, other US and foreign government agencies, and NGOs.

**2.9.7. Cultural Context for Expeditionary Response.** IHS advanced crisis leadership capabilities help commanders and health professionals cultivate cultural awareness, develop a vision for health engagement courses of action, develop and implement culturally acceptable risk communication and media products, build and maintain effective teams, and carry out cultural conflict management and negotiation. Advised by a senior IHS member, theater and MAJCOM planners can tailor FFHSR augmentation capabilities to address a wide range of strategic and regional health issues and complexities and medical and health-related humanitarian emergencies that may arise.

**2.9.8. Global Public Health and Health Systems.** Many internationalist experts view infectious disease as potentially the largest threat to human security. Basic public health practices such as sanitation, vaccinations, and hygiene are the best preventers of morbidity and mortality. IHS teams have or know how to access a working knowledge of the capabilities and activities of local public health stakeholders. IHS teams work at their respective levels with expert joint public and environmental health experts to protect the force and to determine potential areas and avenues of engagement with the HN to achieve mission objectives or enhance US national interests.

**2.9.9. Air Force Medical Service Foundational and Core Competency.** IHS members must have a working knowledge of AFMS doctrinal principles and core competencies for expeditionary settings, such as command and control (C2), medical planning, FHP, AE, expeditionary medical systems, human performance and enhancements, and population health. Global health competencies include medical logistics and administration, theater blood support, military support to civil authorities, and refugee support. IHS personnel use this knowledge in support of the AFMS team and as a knowledge base for learning about, collaborating with, and advising PN air components on potential health engagement synergy, interoperability, and capacity development.

**2.9.10. Force Health Protection.** IHS team members will meet all prescribed FHP measures IAW theater guidance and mission-specific requirements.

***Section 2B—Operations***

**2.10. Deployment Planning and Management.** IHS personnel at all geographic and ARC headquarters provide expert input on GHE operational planning and management. The C-NAF IHS team is responsible for providing or arranging provision of a qualified IHS representative early in the planning cycle, as requested by the C-NAF SG. This representative must have the IHS SEI-required planning knowledge but is not required to be an R-prefix medical contingency planner. The IHS representative may be designated the medical planner for a mission if qualified but more likely will work closely with and provide SME input to the designated medical or line planner to ensure that FFHSR UTCs are appropriately employed. C-NAF IHS teams work closely with the IHS Program Office and pertinent MAJCOM IHS teams to ensure FFHSR UTCs identified in theater time-phased force deployment data (TPFDD) are in a constant state of readiness. C-NAF team functional areas of responsibility include threat assessment, IHS role identification, determining mission-specific UTC capabilities and response, mission and operational readiness evaluations, and AEF organization and integration.

**2.11. Deployment and Employment.** IHS personnel function as SME advisors and action officers for the deployed SG, DMC, or liaisons with security sector and civilian local and international health authorities. FFHSR can be employed as an on-ground, forward-deployed headquarters (AFFOR, JTF, CJTF) asset to assist in mission planning and execution. FFHSR may also be attached to tactical assets such as EMEDS, Air Advisor Teams, and a variety of Air Force or joint elements involved in health engagement activities. The team becomes part of the appropriate gaining AFFOR, JTF, or CJTF command element from time of deployment to the point of redeployment. FFHSR has no stand-alone capability but is involved in the full spectrum of operations. A senior FFHSR filled by a skilled O-5 may be deployed to meet specific requirements for IHS core competencies to support USG, CCDR, and AFMS engagements with the international medical and humanitarian response communities. This individual may be employed to support a rear-area headquarters (combatant command, MAJCOM, AFFOR, JTF, CJTF, or coalition headquarters), a civilian equivalent such as an embassy country team or UN health cluster, or a survey team such as a humanitarian assistance survey team (HAST).

**2.11.1. AEF Support to Theater Contingency Plans.** FFHSR UTCs are elements of TPFDD that operational and logistics planners use to route forces to meet theater deliberate planning requirements. As standard FF series force packages, FFHSR UTCs are listed in the unit type code availability (UTA) database for Air Staff, theater planners, and MAJCOMs to use in deliberate and crisis action planning and AEF theater support.

**2.11.2. Support to Multi-Agency HA Response.** Within the scope of its capabilities, FFHSR can be deployed to support multi-agency pre-crisis planning, crisis action planning, and response for HA missions such as refugee and displaced persons support, priority direct patient services, management and triage of mass populations, disease surveillance and control, and HIV/AIDS and other communicable disease prevention. FFHSR can help task force commanders with assigning health support responsibilities and identifying health challenges and courses of action at the strategic planning and area-specific mission planning levels. FFHSR can facilitate task force interfaces with civil support, US, and foreign government agencies and IOs.

**2.11.3. Support for Security Cooperation.** Within the sphere and scope of its capability, FFHSR can leverage its health cooperation and diplomacy skills to support theater security cooperation activities. IHS personnel assist in devising and executing phase 0 country and regional health engagement strategies that help build partnerships and partnership capacity in the security and civilian health sectors. FFHSR may support medical elements of JCS, combatant command, component, and coalition campaigns, operations, and exercises to include peacetime MEDCAP and MEDRETE activities. IHS personnel have the knowledge to help transform these types of missions from simple, short-term, direct care activities to comprehensive health engagements that create a foundation for enduring BP and BPC and meeting CCDR objectives.

**2.11.4. Support to Medical Stability Operations (MSO).** FFHSR can provide medical support to stability operations in permissive and non-permissive environments. The health sectors in areas and countries that suffer instability typically are rudimentary. Low-level public health interventions (sanitation, clean water, immunizations, and basic health attention) have been shown to have the biggest impacts on overall reduction of local morbidity and mortality. FFHSR can help commanders and planners prepare, plan, execute, and transition operations and projects that best support the MSO mission to optimize the use of time and resources. See JP 3-07 for more information on stability operations.

**2.11.5. Civil-Military Operations.** IHS personnel work to cultivate relationships with USAID, DHHS, DOS, health-related NGOs, and other organizations. They are familiar with joint civil affairs capabilities and can function in collaboration with or embedded with civil affairs teams in developing and executing medical civil-military operations (CMO). Through reachback and relationships with USG civilian partners and on-ground, in-country interaction with civilian organizations and health experts, IHS personnel can build medical bridges that enhance and support partnerships to achieve commander objectives.

**2.11.6. IHS Support to EMEDS.** FFHSR can be tasked with EMEDS HRT to provide planning, liaison, and execution support for EMEDS operations that involve foreign nationals or other organizations outside of DOD (e.g., FHA/DR, security cooperation, MSO, and BP). While FFHSR personnel typically engage in execution and liaison activities more than planning activities at the employed location, they should continue to review OPLANs. They should advocate for and assist with adjustments as the situation warrants and be actively involved in any new planning that occurs. As liaisons for the facility, they focus on gaining knowledge of and building relationships with HN and other health care organizations in the AOR and with the support and direction of the commander work to foster interoperability.

**2.12. Redeployment.** During the redeployment phase, IHS teams provide coordination between new and departing counterparts and provide continuity and maintenance of medical information related to local and multinational health capabilities. A primary role of the IHS team is to help optimize the transition from US military health operations to HN or other agency leads, as appropriate.

***Section 2C—Command, Control, Communications, and Intelligence***

**2.13. Command and Control (C2).** The chain of command for expeditionary medical teams is through the line of the Air Force as outlined in Air Force Doctrine Annex 3-0, *Operations and Planning,* and Annex 3-30, *Command and Control.* IHS assets are integrated within the task force structure established to support the contingency operation. IHS-specific items are outlined in the operation order (OPORD) in Annex C. Annex Q contains general IHS support guidance.

**2.13.1. Component Numbered Air Forces (C-NAFs).** C-NAFs with full-time IHS personnel assigned in the unit manning document will be tasked with requirements for FFHSR in their designed operational capability (DOC) statements. C-NAFs will use personnel and training data to report IHS deployment capabilities and shortfalls in the Status of Resources and Training System (SORTS) and AEF Reporting Tool (ART). C-NAFs will use the ART to evaluate UTC capability and status.

**2.13.2. IHS Program Office, Air Force Medical Support Agency (AFMSA/SG3XI).** The IHS Program Office serves as the focal point and functional manager for the IHS SEI and maintains a database of personnel information and training completion records of AFMS personnel holding IHS SEIs other than those individuals already assigned to a full-time IHS position on a C-NAF unit manning document (UMD). These personnel may be available for AEF and crisis-action deployment tasking when the C-NAFs cannot source the requirement. The IHS Program Office validates IHS capabilities-based requirements to ensure availability of IHS personnel to support worldwide expeditionary operations and coordinates with the Air and Space Expeditionary Force Center (AEFC) for FFHSR and individual IHS augmentation deployments.

**2.13.3. Deployed Commands.** Deployed commanders from the joint or combined task force level to an individual EMEDS unit may call for regional or globally focused IHS support. C-NAF/MAJCOM IHS teams, the IHS Program Office, and ARC liaisons are closely involved with Air Force and joint command planners to ensure appropriate tasking of IHS resources in deployment and exercise plans. Unless stated otherwise in MAJCOM reporting instructions, the deployed US air component commander will exercise operational control (OPCON) and administrative control (ADCON) of IHS personnel in direct support of non-special operations ground and naval forces. OPCON and ADCON of deployed AFSOC IHS personnel will be exercised through the deployed special operations command.

**2.14. Communication Requirements.** FFHSR does not deploy with its own communications equipment and relies on the element to which they are assigned or attached for support. FFHSR requires access to the Defense Switched Network (DSN), secure voice communication, Nonsecure Internet Protocol Router Network (NIPRNET), and Secret Internet Protocol Router Network (SIPRNET). Depending on the mission, FFHSR may require land mobile radios (LMRs) to communicate with supported deployed medical facilities and international enabled mobile or satellite phone capability. Ideally, IHS communication requirements should be clarified and requested during pre-deployment planning.

**2.15. Intelligence.** At the employment location, IHS teams receive medical intelligence reports through the theater medical director or the task force medical advisor. Medical intelligence also may be gathered from other sources such as NCMI, other USG agencies, IOs, NGOs, and the private sector.

***Section 2D—Security***

**2.16. Site Security and Arming of Medical Personnel.** Medical personnel and equipment are non-combatant assets as defined by the Geneva Conventions and the Law of Armed Conflict (LOAC). Medical personnel and war reserve materiel (WRM) assemblages are protected IAW AFI 31-101, *Integrated Defense.* Local security measures are outlined in the Integrated Defense Plan. Medical personnel are authorized arms IAW AFI 31-117, *Arming and Use of Force by Air Force Personnel.* To maintain non-combatant status, IHS may provide site security only within the immediate area of their medical facility or if patients are present.

**2.17. Operations Security (OPSEC).** IHS personnel must protect mission-critical information IAW CCDR OPSEC policy and AFI 10-701, *Operations Security (OPSEC).* Classified information must be transmitted by secure means and protected IAW AFI 31-401. Situation reports (SITREPs), medical surveillance, site locations, and compiled patient data are examples of information that may be classified.

**2.18. Information Assurance (IA) Policy.** IHS members must understand and follow IA procedures, to include communications security (COMSEC) and computer security (COMPUSEC), IAW AFI 33-200, *Information Assurance (IA) Management,* AFMAN 33-282, *Computer Security (COMPUSEC),* and associated Air Force IA guidance.

**2.19. Security of Weapons and Ammunition**. IHS members may maintain issued weapons and ammunition when authorized. Weapons and ammunition must be secured IAW AFI 31-101, AFMAN 31-229, *USAF Weapons Handling Manual,* and local procedures.

***Section 2E—Integration and Interoperability***

**2.20. Integration of IHS Personnel into the Full Spectrum of Operations.** IHS personnel who are assigned or deployed to theaters of operation can be involved in pre-deployment, deployment, and redeployment phases. The global health capabilities and prior activities of IHS personnel in the theater can provide the CCDR with medical guidance and critical information to enhance operations. As AFMS assets interface with global health systems in the different AORs, IHS personnel can build and solidify HN relationships that can be leveraged by the regional commands in security cooperation, ongoing operations of any type, or contingency response operations. IHS personnel train to integrate smoothly into joint and USG interagency operations and UTCs to include assignment within another Service unit.

**2.21. Interoperability in the Area of Responsibility (AOR).** IHS personnel provide a basic knowledge of the foreign aeromedical assets in the country or AOR and interoperability with Air Force assets. Specialized medical expert exchanges may be arranged to provide subject matter expertise for information exchange and training when requested by a host country. Agenda

items are pre-coordinated through discussions between the AFMS interface with the host country and are designed to help enhance HN capabilities.

***Section 2F—Training***

**2.22. Training Requirements.** Initial and sustainment training are required to maintain the operational and clinical capability of IHS personnel. FFHSR members must meet all initial training requirements and complete sustainment training IAW AFI 41-106, *Medical Readiness Program Management,* and the Readiness Skills Verification Program (RSVP) before they can deploy in an IHS team role. These requirements are not waiverable.

**2.23. Mobility Assignment Criteria.** FFHSR positions are initially filled by full-time IHS personnel stationed at the appropriate geographic command or numbered Air Force for the deployment or exercise location. The request for forces (RFF) owner should contact the IHS Program Office for assistance if manpower needs exceed the capabilities of the geographic command or numbered Air Forces. The program office maintains a list of IHS SEI holders with specific language capability and geographical area expertise who may not be in IHS billets. If they are unable to identify or receive permission to deploy an individual from this list, the RFF owner can request members from MTFs with an assigned FFHSR regardless of language or regional experience.

**2.24. Unit Type Code (UTC) Training.** FFHSR training consists of the following elements:

**2.24.1.** AFSC-specific core RSVP and other medical readiness training IAW AFI 41-106.

**2.24.2.** EMEDS training every three years.

**2.24.3.** IHS core competencies required for SEI 452 or H8A, H8B, or H8C IAW AFI 44-162. Maintenance of skills training is tracked by the IHS Program Office and is required annually.

**2.24.4.** Additional training as dictated by regional or mission-specific requirements, global employment of the force, TCPs, Air Force campaign support plan, GHE guidance, and DOS mission program plans.

**2.25. Chemical, Biological, Radiological, and Nuclear (CBRN) Defense Training.** All personnel subject to deployment must receive CBRN defense training IAW AFI 41-106 and AFI 10-2501, *Air Force Emergency Management (EM) Program Planning and Operations.* All personnel should be familiar with the concepts of counter-chemical warfare as outlined in AFMAN 10-2503, *Operations in a Chemical, Biological, Radiological, Nuclear, and High-Yield Explosive (CBRNE) Environment.*

**2.26. Other Training Platforms.** The Office of the Air Force Surgeon General (AF/SG) has worked to develop training opportunities in collaboration with the Air Force Culture and Language Center (AFCLC), other Services, and within the interagency civilian sector through the IHS Program Office and the Uniformed Services University of the Health Sciences. IHS

personnel have taken advantage of training offered at such diverse venues as Johns-Hopkins University (Health Emergencies in Large Populations Course), the Foreign Language Training Center Europe, George C. Marshall European Center for Security Studies, the US Agency for International Development's Office of Foreign Disaster Assistance (Joint Humanitarian Operations Course), Disaster Assistance Response Team training, and the Center of Excellence in Disaster Management (Combined Humanitarian Assistance Response Training).

***Section 2G—Logistics***

**2.27. Expeditionary Combat Support and Base Operating Support (ECS/BOS).** FFHSR is not a stand-alone UTC and requires ECS/BOS from the gaining command. ECS/BOS requirements include but not limited to billeting, messing and other consumable materials, power, water, ice, latrines, showers, laundry, waste management, exterior lighting, transportation, fuels, vehicle maintenance, equipment maintenance, general supplies, contracting, information and communications systems support, mortuary affairs, public affairs, chaplain, linguist, personnel and vehicle decontamination, and security. If an FFHSR away mission terminates at a location different from the host command or deployed IHS team's location, the senior member will ensure the team receives necessary support while it awaits transportation. If IHS teams are separated from the host command, the senior IHS member will contact the base command post to obtain necessary support until the team returns to its assigned location. See Attachment 2 for quantified estimates on ECS/BOS requirements.

THOMAS W. TRAVIS
Lieutenant General, USAF, MC, CFS
Surgeon General

## Attachment 1

## GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

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### *Acronyms and Abbreviations*

**AAMIMO—**Advanced Aerospace Medicine for International Medical Officers
**AAR—**After Action Report

**ACC**—Air Combat Command
**ADCON**—Administrative Control
**ADLS—**Advanced Distributed Learning Service
**ADVON—**Advanced Echelon
**AE—**Aeromedical Evacuation
**AEF—**Air and Space Expeditionary Force
**AEFC—**Air and Space Expeditionary Force Center
**AF—**Air Force
**AFCLC—**Air Force Culture and Language Center
**AFFOR—**Air Force Forces
**AFGPS—**Air Force Global Partnership Strategy
**AFI—**Air Force Instruction
**AFMAN—**Air Force Manual
**AFMS—**Air Force Medical Service
**AFMSA**—Air Force Medical Support Agency
**AFPC—**Air Force Personnel Center
**AFPD—**Air Force Policy Directive
**AFRC—**Air Force Reserve Command
**AFSAT**—Air Force Security Assistance Training (squadron)
**AFSC—**Air Force Specialty Code
**AFSOC**—Air Force Special Operations Command
**AFTTP—**Air Force Tactics, Techniques, and Procedures
**AHLTA—**Armed Forces Health Longitudinal Technology Application
**ANG—**Air National Guard
**AO—**Area of Operations
**AOR—**Area of Responsibility
**ARC—**Air Reserve Component
**ART—**AEF Reporting Tool
**ASIMS—**Aeromedical Services Information Management System
**BEAR—**Base Expeditionary Airfield Resources
**BOS**—Base Operating Support
**BP—**Building Partnerships
**BPC—**Building Partnership Capacity
**C2—**Command and Control
**C-MAJCOM—**Component Major Command
**C-NAF**—Component Numbered Air Force
**CAA**—Combat Aviation Advisor
**CBRN—**Chemical, Biological, Radiological, and Nuclear
**CBRNE—**Chemical, Biological, Radiological, Nuclear, and High-Yield Explosive
**CCDR—**Combatant Commander
**CDC**—Centers for Disease Control and Prevention
**CJTF—**Commander, Joint Task Force
**CMO—**Civil-Military Operations
**CMOC—**Civil-Military Operations Center
**COIN—**Counterinsurgency
**COMAFFOR—**Commander, Air Force Forces

**COMPUSEC**—Computer Security
**COMSEC**—Communications Security
**CONOPS—**Concept of Operations
**CONUS**—Continental United States
**CSAF**—Chief of Staff, United States Air Force
**CTFP—**Combating Terrorism Fellowship Program
**DHHS—**Department of Health and Human Services
**DHP—**Defense Health Program
**DIA**—Defense Intelligence Agency
**DIMO**—Defense Institute for Medical Operations
**DISAM**—Defense Institute for Security Assistance Management
**DMC—**Deployed Medical Commander
**DOC—**Designed Operational Capability
**DOD—**Department of Defense
**DODD—**Department of Defense Directive
**DOEHRS—**Defense Occupational and Environmental Health Reporting System
**DOS**—Department of State
**DR**—Disaster Relief
**DSCA—**Defense Security Cooperation Agency
**DSN—**Defense Switched Network
**E-IMET—**Expanded-International Military Education and Training
**ECU—**Environmental Control Unit
**ECS**—Expeditionary Combat Support
**EM—**Emergency Management
**EMEDS—**Expeditionary Medical Support
**FHA—**Foreign Humanitarian Assistance
**FHP—**Force Health Protection
**FMS—**Foreign Military Sales
**GCC**—Geographic Combatant Commander
**GEF—**Guidance for Employment of the Force
**GHE—**Global Health Engagement
**HA**—Humanitarian Assistance
**HAF—**Headquarters, Air Force
**HAST—**Humanitarian Assistance Survey Team
**HCA**—Humanitarian and Civic Assistance
**HN**—Host Nation
**HRT—**Health Response Team
**IA—**Information Assurance, International Affairs
**IAW—**In Accordance With
**IFRC—**International Federation of Red Cross and Red Crescent Societies
**IGO**—Intergovernmental Organization
**IHR—**International Health Regulations
**IHS**—International Health Specialist
**IMET—**International Military Education and Training
**IO**—International Organization
**ITO—**Invitation Travel Order

**JAG—**Judge Advocate General
**JCA—**Joint Capability Area
**JCS—**Joint Chiefs of Staff
**JFACC**—Joint Force Air Component Commander
**JFC**—Joint Force Commander
**JFS**—Joint Force Surgeon
**JP—**Joint Publication
**JTF—**Joint Task Force
**KX—**Knowledge Exchange
**LIMFAC—**Limiting Factor
**LMR—**Land Mobile Radio
**LNO**—Liaison Officer
**LOAC—**Law of Armed Conflict
**M&E—**Monitoring and Evaluation
**MAJCOM—**Major Command
**MEDCAP—**Medical Civic Action Program
**MEDRETE—**Medical Readiness Training Exercise
**MEFPAK**—Manpower and Equipment Force Packaging
**MILDEP**—Military Department
**MISCAP—**Mission Capability
**MOA**—Memorandum of Agreement
**MOD—**Ministry of Defense
**MOE—**Measure of Effectiveness
**MOH—**Ministry of Health
**MOP—**Measure of Performance
**MOU**—Memorandum of Understanding
**MPA—**Manpower Personnel Appropriation
**MPEP—**Military Personnel Exchange Program
**MRA**—MEFPAK Responsible Agency
**MSO—**Medical Stability Operations
**MTF**—Medical Treatment Facility
**MTT—**Mobile Training Team
**MTW—**Major Theater War
**NATO—**North Atlantic Treaty Organization
**NCMI—**National Center for Medical Intelligence
**NCO—**Noncommissioned Officer
**NGB**—National Guard Bureau
**NGO**—Non-Governmental Organization
**NIPRNET—**Nonsecure Internet Protocol Router Network
**OCONUS**—Outside the Continental United States
**OFDA—**Office of United States Foreign Disaster Assistance
**OPCON**—Operational Control
**OPLAN—**Operation Plan
**OPORD—**Operation Order
**OPR—**Office of Primary Responsibility
**OPSEC—**Operations Security

**PHO—**Public Health Officer
**PKO—**Peacekeeping Operations
**PN—**Partner Nation
**POC—**Point of Contact
**POL—**Petroleum, Oils, and Lubricants
**POM—**Program Objective Memorandum
**PVO**—Private Voluntary Organization
**RCC—**Rescue Coordination Center
**RegAF**—Regular Air Force
**RFF—**Request for Forces
**ROMO—**Range of Military Operations
**RPA—**Reserve Personnel Appropriation
**RSVP**—Readiness Skills Verification Program
**SAF—**Secretary of the Air Force
**SCETWG**—Security Cooperation Education and Training Working Group
**SCO—**Security Cooperation Officer
**SEI**—Special Experience Identifier
**SG—**Surgeon General, Surgeon
**SIPRNET—**Secret Internet Protocol Router Network
**SITREP**—Situation Report
**SME—**Subject Matter Expert
**SMEE—**Subject Matter Expert Exchange
**SMO**—Senior Medical Officer
**SOF—**Special Operations Forces
**SORTS—**Status of Resources and Training System
**SPP—**State Partnership Program
**STE**—Secure Telephone Equipment
**TCP**—Theater Campaign Plan
**TDY—**Temporary Duty
**TPFDD**—Time-Phased Force Deployment Data
**TRAC2ES—**United States Transportation Command Regulating and Command and Control Evacuation System
**TSCMIS—**Theater Security Cooperation Management Information System
**TTP—**Tactics, Techniques, and Procedures
**UMD—**Unit Manning Document
**UN**—United Nations
**USAFSAM—**United States Air Force School of Aerospace Medicine
**USAID**—United States Agency for International Development
**USCENTCOM**—United States Central Command
**USG—**United States Government
**USMILGP**—United States Military Group
**USPHS**—United States Public Health Service
**USSOCOM—**United States Special Operations Command
**UTA—**Unit Type Code Availability
**UTC—**Unit Type Code
**WHO—**World Health Organization

**WMD**—Weapons of Mass Destruction
**WMP—**War and Mobilization Plan
**WRM—**War Reserve Materiel

## Attachment 2

## EXPEDITIONARY COMBAT SUPPORT (ECS) REQUIREMENTS

| IHS ECS REQUIREMENTS | |
|---|---|
| **ECS calculations are IAW AFP 10-219, Vols 5 & 6, where applicable and data provided.** | |
| | **FFHSR (Personnel Only)** |
| **MOVEMENT REQUIREMENTS Calculations IAW AFPAM 10-1403 and DTR 4500.9-R, Part III** | |
| Pallets (#) | |
| C-27 (# aircraft) | |
| C-130 (# aircraft) | |
| C-17 (# aircraft) | |
| C-5A (# aircraft) | |
| M871 (# flatbed semitrailers) | |
| M872 (# flatbed semitrailers) | |
| **SITE PREPARATION** | |
| Square Footage (slight grade required) | |
| Tents (#) | |
| ECUs (# units) | |
| **BASE EXPEDITIONARY AIRFIELD RESOURCES (BEAR) REQUIREMENTS** | |
| Latrine/Showers (# staff) | 1 |
| Billeting (# personnel) | 1 |
| # Officer | 1 |
| # Enlisted | 0 |
| Meals (meals/day, staff) (= 3 meals/day) | 3 |
| Laundry (lbs/week, staff) (= 32 lbs/person/week) | 32 |
| Ice (lbs/day, staff) (= 4.4 lbs/person/day) | 4.4 |
| Potable Water (gal/day) (= # staff x 10 gal/day) | 10 |
| Power (kW) (3-phase) | |
| **CIVIL ENGINEERING REQUIREMENTS** | |
| **Medical/Biohazard Waste** | |

| IHS ECS REQUIREMENTS | |
|---|---|
| **ECS calculations are IAW AFP 10-219, Vols 5 & 6, where applicable and data provided.** | |
| | **FFHSR (Personnel Only)** |
| Liquid (gal/day, staff) (= 0.7 x potable water rate) | 7 |
| Solid (lbs/day, staff) (= 4 lbs x # people) | 4 |
| **LOGISTICS REQUIREMENTS** | |
| **POL** | |
| Diesel Fuel (gal/day) (=8.33 gal/hr x 24hrs) | |
| Diesel Fuel, CP-EMEDS Mode (gal/day) | |
| Unleaded Fuel (gal/day) (10kW backup generator) | |
| **Vehicles** | |
| Vehicle Maintenance Support | |
| Vehicle Requirements | |
| Material Handling Equipment | |
| **COMMUNICATIONS AND INFORMATION SYSTEMS REQUIREMENTS** | |
| **Communications Equipment** | |
| Phone (# lines) (**Note:** None organic; external support required) | 1 |
| Satellite/Telemedicine (# equipment) | None organic; support required |
| Land Mobile Radios (# equipment) | |
| Secure Telephone Equipment (# equipment) | |
| Controlled Cryptographic Items (**Note:** None organic; relies on base communications units for STE cards) | |
| **Information Systems and Network Support** | |
| Laptop (# equipment) | None organic; support required |

| IHS ECS REQUIREMENTS | |
|---|---|
| **ECS calculations are IAW AFP 10-219, Vols 5 & 6, where applicable and data provided.** | |
| | **FFHSR (Personnel Only)** |
| Printers (# equipment) | None organic; support required |
| SIPRNET Access | Required |
| NIPRNET Access | Required |
| Operating System/Office Suite | DOD SDC |
| RAM/Hard Drive | ITT Standard |
| Clinical Applications | TMIP-AF |
| Required Port Number/Protocol Access (TCP/UDP) | 21/TCP; 443/TCP; 8080/TCP |
| **Required Website Access** | |
| AHLTA | https://warrior-sa.lrmc.amedd.army.mil |
| ASIMS | https://www.afchips.brooks.af.mil/webApp/USG_Notice_Consent.aspx?NextForm=login.aspx |
| DOEHRS | https://doehrswww.apgea.army.mil/front.htm |
| KX | https://kx2.afms.mil/Pages/default.aspx |
| NCMI | https://www.intelink.gov/ncmi/index.php |
| TRAC2ES | https://www.trac2es.transcom.mil/ |
| **CHAPLAINCY SERVICE SUPPORT** | |
| | Required |
| **SECURITY FORCES SUPPORT** | |
| | Required if not collocated on military installation |

## Attachment 3

## MONITORING AND EVALUATION FRAMEWORK

A3.1. Monitoring and evaluation (M&E) is fundamental in the planning, execution, and assessment of AFMS GHE. Approximately 10 percent of a program budget may be required for M&E. Assessments should include both measure of performance (MOP) and measure of effectiveness (MOE). MOP (or outputs) can be defined as a measure of how well the stated tasks were accomplished. MOE (or outcomes) can be defined as a measure of the impact and effectiveness of the accomplished task.

A3.2. The objectives should be driven by and account for the views and opinions of both the HN and local community and agreed upon (to the extent possible) by key stakeholders. Local personnel and resources should be used to the extent possible. The long-term goal is that local personnel will assume ownership of the program.

A3.3. The role of each team member should be defined in writing. This will help ensure that expectations are reasonable and achievable, form a basis for M&E, and establish a basis for the training of HN personnel.

A3.4. Program planning steps should include the following:

- Determine need for the program or activity
- Determine objectives (i.e., output and outcome)
- Obtain appropriate funding
- Design activities (include plans for both output and outcome measures)
- Control resources (e.g., funding, manpower, equipment, infrastructure)
- Conduct activities
- Assess outputs and outcomes

A3.5. While there is no standardized methodology for assessment within DOD, the USG, or across the NGOs, the M&E logic model shown in Figure A3-1 is gaining increased acceptance as a framework for program planning and evaluation. It can be used to link activity with CCDR security cooperation objectives, address MOPs (outputs), and evaluate effectiveness (short-term, intermediate, and long-term outcomes).

**Figure A3-1. M&E Logic Model.**

| Inputs (Activities) | Outputs (Measures of Performance) | | Outcomes (Measures of Effectiveness) | | |
|---|---|---|---|---|---|
| **What we invest** | **What we do** | **Who we reach** | **Short-Term** | **Intermediate** | **Long-Term** |
| –Activity | –MTT | –Participants | Change in: | Change in: | Change in: |
| –Funding | –SMEE | –Patients | –Knowledge | –Behaviors | –Coalition & PKO |
| –Equipment | –Conference | –Rx | –Skills | –Practices | –Doctrine |
| –Facility | –MEDRETE | –Procedures | –Attitude | –Policies | –Interoperability |
| | –Others | –Others | –Motivation | –Procedures | –Environmental, social, economic, political conditions |
| | | | –Awareness | –Capability | –Others |
| | | | –Others | –Others | |

**External Influences, Environmental, Related Programs**

## Attachment 4

## FUNDING GUIDANCE

A4.1. In general, Defense Health Program (DHP) funds are not used for execution of GHE or HA/DR activities. Various sources of funding exist for mission execution. Coordinate with your functional manager to determine funding and to program for use of combatant command or C-NAF funds.

A4.2. For GHE, DHP funds can be used for training of personnel and for temporary duty (TDY) assignments directly related to the primary mission of the AFMS, including international travel. Funding requests for GHE activities for the objective of training AFMS personnel must be vetted through the Force Development and Medical Readiness Panels for approval and prioritization.

A4.3. The following questions must be answered before considering DHP dollar use:

- Does the expense bear a logical relationship to the DHP appropriation and make a direct contribution to an authorized AFMS function? **Answer must be yes.**

- Is the expenditure prohibited by law? **Answer must be no.**

- Does the expenditure fall within the scope of another appropriation or statutory funding scheme or is it otherwise provided for in a different appropriation? **Answer must be no.**

A4.4. The following are frequently asked questions regarding use of DHP dollars for GHE:

- Q1: I am on a combatant command/C-NAF staff. Can DHP dollars be used for my ongoing training?

  A1: Yes. DHP dollars can be used for continuing military education and other activities outlined above. Line dollars should be used for mission-related TDY assignments.

- Q2: I need to travel to the combatant command for the annual Theater Cooperation Synchronization meeting. These meetings are unit funded. Who pays for me?

  A2: If there are no dedicated funds from the combatant command or C-NAF for this requirement, then the use of DHP dollars is permissible.

- Q3: I did not complete all my IHS training before reporting to my new duty station (combatant command/C-NAF.) Can DHP pay for this?

  A3: Yes. However, approval must be obtained from AFMSA/SG3XI first for any training that is not on the approved course list.

- Q4. We would like to use some of our DHP training dollars for an exercise in another country where there would be less need to simulate limiting factors (LIMFACs). Is this legal?

A4: Maybe. You must demonstrate a bona fide need of why this cannot be simulated locally. Caveat: There are currently no concrete training objectives delineated that satisfy the bona fide need mandate to train in a foreign country.